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Original Article

PSYCHIATRIC MORBIDITY IN A RURAL COMMUNITY IN KERALA

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ABSTRACT

A survey was conducted in a rural community in Kerala in order to assess the psychiatric morbidity in the region. The prevalence of mental illness was 12.95 per 1000 and that of psychoses was 5.29 per 1000. Although the overall prevalence of mental disorders was low when compared with data from other part of India, the figures for psychoses were comparable. The issue involved are discussed.

INTRODUCTION

Epidemiological enquiries in the field of mental health have been conducted in different parts of India (Seshadri, 1986). However, no such investigation has been done in the State of Kerala. This survey attempts to fill this lacuna.

METHOD

The study was conducted in Vettikkal village which is one of the four villages adopted by the Community Health Department of the Malankara Orthodox Syrian Church Medical Mission Hospital, Kolencherry, Ernakulam Distrit, Kerala, for community development since 1985. The village has 529 households and the department has 5 community health volunteers, each looking after approximately 100 families. These volunteers hail from the same village and are young, unemployed, single women who have passed SSLC. They are paid an honorarium by the hospital.

The Indian Psychiatric Survey Schedule (IPSS), Section I, Sub-section 10 (Issac & Kapur, 1980; Kapur & Carstair, 1974) was translated into Malayam by a Psychiatric Social worker who knew both languages (English & Malayam) and was familiar with psychiatric concepts. The requisites of translation were clarity, simplicity and the economy of expression. A psychiatrist who was also competent in both languages retranslated the vernacular version into English in order to establish linguistic and conceptual equivalence. The two translators discussed the instrument item by item to make the translation as approximate as possible to the original version. The vernacular version was taken administered to 10 individuals. Based on the experience gained some minor changes were made and the questionnaire was finalised. The community health volunteers were then trained to administer the instrument.

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TABLE I : DETAILS OF PSYCHIATRIC MORBIDITY (ICD-9)

PSYCHIATRIC MORBIDITY		ADULTS		CHILDREN	
		No.	CASES/1000	No.	CASES/1000
TOTAL POPULATION		1699		724	
295	Schizophrenia	5	2.94	1	
296	Affective Psychosis	3	1.77	–	
297	Paranoid States	1	0.58	–	
300	Neuroses	2	1.18	–	
303	Alcohol Dependence	4	2.35	–	
319	Mental Retardation	4	2.35	4	5.52
345	Epilepsy	3	1.77	–	
	Total	22	12.95	4	5.52

The study was conducted in two stages. In the first stage, the community health volunteers visited each house in the village and obtained socio-demographic data. They administered the questionnaire to the lady of the house and in her absence to another adult member. If any of the 15 questions were positive the particular individual was considered as a potential case. In the second stage, a psychiatrist (JV) visited households where potential cases had been identified. Detailed psychiatric examination was done for such individuals and the diagnosis made in accordance with the International Classification of Diseases - 9 (WHO, 1978). This survey was conducted in 1990.

RESULTS

The survey was completed in 500 houses. 29 household were not covered either because of non-cooperation or repeated absence of members from their homes during the study period. The total population covered was 2423 and included 1699 adults (defined as 18 years and above) and 724 children. Of these 1224 were male and 1199 female.

In the first stage 39 potential cases were identified by the community health volunteers. Detailed psychiatric examination was done on 37 individuals by a psychiatrist. One individual died in a motor accident and another committed suicide before psychiatric evaluation was done. The details of the psychiatric morbidity are documented in Table 1. 26 individuals were found to have psychiatric morbidity and they included 4 children with mental retardation. The prevalence rate for the total psychiatric morbidity and for psychoses was 12.95 per 1000 and 5.29 per 1000 respectively.

DISCUSSION

This is the first study from Kerala to assess mental disorders in the commnity. The use of a standardized screening instrument

which has been designed and validated for Indian conditions ensured reliable screening. The coverage of the population was also high suggesting that the values obtained were a reasonable reflection of the true population figures.

The overall prevalence of mental disorders were found to be low in comparison to other Indian data (Seshadri, 1986). The wide variation in the total psychiatric morbidity reported (9.5 - 369 per 1000) in different investigations can be explained by differences in methodology in general and with regard to case screening and definition in particular. However, the prevalence of psychoses and schizophrenia were comparable with studies carried out in other regions as severe mental morbidity would have been easily identified.

The IPSS sub-section employed to identify mental disorders in our study has been documented to be a sensitive tool for the identification of psychoses (Isaac & Kapur, 1980). In addition, the use of this protocol is economical in terms of the time required for administration and for training personnel in its use. However, its limitations include its low sensitivity to identify minor psychiatric morbidity and neuroses. Affective illness may also be under reported with this instrument as individuals who are symptom free at the time of screening would not be included. In this study two individuals with a past history of affective disorders were not included as they were euthymic during the survey. The low rates of neurosis, alcohol dependence and epilepsy compared to other surveys could be due to the reduced sensitivity of the instrument as it has been primarily designed to identify psychoses.

Nevertheless, despite its limitations, this study adds to the limited information available about psychiatric morbidity in rural Kerala, especially with regard to the prevalence of psychoses. More research, keeping in mind the issues discussed, is necessary to identify mental disorders and related problems in the community and to plan appropriate mental health care.

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